STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF EXAMINATION

OF

UNITED HEALTHCARE OF UTAH

OF

SALT LAKE CITY, UTAH

As Of

December 31, 1999

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September 10, 2001

Honorable Merwin U. Stewart
Insurance Commissioner
State of Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Sir:

An examination has been conducted as of December 31, 1999, in accordance with your instructions, and in compliance with the insurance laws of the State of Utah, of the financial condition and business affairs of

UNITED HEALTHCARE OF UTAH,
Salt Lake City, Utah,

a health maintenance organization (HMO) hereinafter referred to in this report as the Organization.

HISTORY

The Organization was issued a Certificate of Incorporation under the name of Physicians Health Plan of Utah by the Office of the Lieutenant Governor of the State of Utah during March 1984. The initial Articles of Incorporation authorized the issuance of 5,000,000 shares of stock at a par value of $.01 each. The Organization was issued a Certificate of Authority by the Utah Insurance Department and commenced business during August 1984. The Articles of Incorporation were amended during July 1992 to change the name of the Organization to United HealthCare of Utah.

The Organization became part of an insurance holding company system on December 30, 1986, when United HealthCare Services, Inc. (UHS), a Minnesota corporation than known as Charter Med Inc., acquired 50% equity interest in it. A cash offer was made to purchase all outstanding shares of the Organization in November of 1990 by UHS, than known as UHC Management Company. The offered expired January 31, 1991, at which time UHS stock ownership approximated 85% of the total outstanding shares. UHS again increased its ownership of the Organization to approximately 92% in December of 1994 through a tender offer, which was approximately the percent of ownership as of December 31, 1999. UHS was a wholly owned subsidiary of United HealthCare Corporation (United), the ultimate controlling entity of the holding company system.

The Organization was federally qualified as an independent practice association model health maintenance organization on October 4, 1985. It voluntarily relinquished its federal qualification on November 9, 1991.

March 6, 2000, subsequent to the period of examination, United changed its name to UnitedHealth Group Inc. The holding company system was then restructured when UHS transferred all of its outstanding shares of the Organization to its wholly owned subsidiary, UnitedHealthcare Inc., on June 30, 2000.

NET WORTH

The number of shares of stock authorized by the Organization as of December 31, 1999, was 5,000 at a par value of $50 each. The number of shares issued and outstanding was 2,379. The balance in the common stock account was $118,950. The balance in the paid in surplus account was $9,148,590.

Capital infusions of $2,500,000 and $4,000,000 were made to paid in surplus in 1997 and 1999 respectively. They were both from the parent of the Organization.

Health maintenance organizations organized and operating in the State of Utah were subject to minimum capital and compulsory surplus standards. The Organization's minimum capital requirement, as of December 31, 1999, was $100,000 pursuant to Utah Code Annotated (UCA) Section 31A-8-209. The Organization's compulsory surplus requirement was $5,144,800 pursuant to UCA Section 31A-8-210.

STATUTORY RESERVES

Pursuant to UCA Subsection 31A-8-211(1), the Organization was required to maintain a deposit in the amount of $2,672,400. The market value of the deposit as of December 31, 1999, was $2,314,024, deficient by approximately $365,000. This deficiency was subsequently corrected, and the amount on deposit as of December 1, 2000, was $2,700,000. The deposit consisted of United States Treasury Notes.

AFFILIATED COMPANIES

The Organization was a member of an extensive insurance holding company system with United being the ultimate controlling person within the system. United was a publicly held developer and marketer of managed care services, owning and managing a network of health maintenance organizations and offering an array of alternative managed care programs and services. The following chart illustrates the direct control relationship between the Organization and its parents.

UNITED HEALTHCARE CORPORATION
United HealthCare Services, Inc.
United HealthCare of Utah

TRANSACTIONS WITH AFFILIATES

Affiliate agreements, as itemized below, defined and controlled various aspects of the Organization's transactions and operations.

Tax Sharing Agreement with United HealthCare Corporation

The Organization's federal tax obligations were reported in United's consolidated federal income tax return pursuant to an agreement effective as of January 1, 1990, as amended effective January 1, 1996. The agreement provided for the allocation of federal, state and local income taxes to the subsidiaries of United essentially on the basis of their contribution to the consolidated tax return.

Management Agreement with United HealthCare Services, Inc.

The Organization executed a management services agreement with its parent, UHC Management Company (UHS) as of January 1, 1993. UHS provided many of the services necessary for the Organization's operation under the agreement. Those services included:

Claims processing, payment to providers, and other administrative activities
Development and implementation of standardized contracts
Assistance in compliance with applicable laws and regulations
General administrative and financial services
Underwriting services
Internal audit services
Support and oversight of marketing, sales, member services, and medical services
Legal services
Assistance in marketing, membership, and public relations material
Recruitment, compensation, and supervision of on-site personnel
Marketing, advertising, promotional, and educational material
Retention of adequate office space, furniture, and equipment
Payments related to consultants or third party advisors.

Administrative fees payable by the Organization to UHS for the above referenced services were 12% of the month's gross revenues.

Administrative Agreement with United Health and Life Insurance Company

Members were indemnified for the cost of medical care received from providers not in the Organization's network under indemnity and out-of-area policies issued by United Health and Life Insurance Company, now known as United HealthCare Insurance Company. The Organization provided administrative services for the affiliate relative to indemnity and out-of-area policies. The Organization was paid 10% of the premium received as compensation for administrative services provided, of which 8% was allocated to UHS. The effective term of this agreement was from January 1, 1993 through December 31, 1993, with automatic renewals for additional one year terms.

The Organization was found to be in non compliance with UCA Section 31A-25-201(1) in the prior examination report based on this agreement. Refer to the subsection of this report entitled Status of Prior Examination Findings for further details.

ASO Program Service Agreement with United HealthCare Services, Inc.

This agreement, effective January 1, 1993, obligated the Organization to maintain and provide access to a network of ASO Providers for employers and groups under an administrative services only program with UHS. UHS was obligated to remit to the Organization financial allowances as defined in contracts between the Organization and the ASO Providers. The Organization was than obligated for the distribution of these allowances to the ASO Providers.

Reinsurance Agreement with United Health and Life Insurance Company

Reference the Reinsurance section of this report.

Contract with United Behavioral Systems, Inc.

The Organization contracted with United Behavioral Systems, Inc., now known as United Behavioral Health, to provide mental health and substance abuse services to members. The term of the agreement was for three years beginning January 1, 1994, and renewed automatically for one year terms. The "standard plan" or "HMO Choice" rate in effect per enrollee and eligible dependent per month was $3.68 from January 1, 1999 through December 31, 1999.

Transplant Services Agreement with United Resources Networks, a Division of UHC Management Company, Inc.

This agreement, effective January 1, 1994, provided access to certain participating providers, contracted with United Resources Networks, a division of UHC Management Company, Inc. (UHS), for the provision of transplant related health care services and supplies. The agreement was effective until termination. It could be terminated at any time upon mutual agreement of both parties, or with 90 days written notice by either party. The fee for this service was $.06 per member per month as of December 31, 1999.

Optum Care24 Services Agreement with United HealthCare Services, Inc.

This agreement, effective January 1, 1996, with UHS, was for the purpose of describing Optum Care24 Services UHS would provide to individuals who have health care coverage through or whose health care coverage was administered by the Organization or UHS. This agreement was subsequently superseded by the Optum Services Agreement as described in the subsection of this report entitled Optum® Services Agreement with Optum, a Division of United HealthCare Services, Inc.

Optum Nurseline Services Agreement with United HealthCare Services, Inc.

This agreement, effective January 15, 1996, obligated UHS to provide Organization members certain health information 24 hours a day, 365 days a year, by a registered nurse by telephone or via an audio health information system. The Organization agreed to offer these services to all of its members in the United States. This agreement was superseded by the Optum Services Agreement as described in the subsection of this report entitled Optum® Services Agreement with Optum, a Division of United HealthCare Services, Inc.

Optum Health Plan Web Site Letter of Agreement with Optum, a Division of United HealthCare Services, Inc.

This agreement, effective January 1, 1998, provided certain health information services to the Organization which included the creation and implementation of a web site, providing of physical site hosting and on-going maintenance, reports regarding the web site, and any corrections or updates for the web site. The one-time development and implementation fee was $10,000 and the ongoing maintenance and enhancement fee was $2,100 per month.

Optum® Services Agreement with Optum, a Division of United HealthCare Services, Inc. (Healthy Pregnancy Services)

This agreement, effective January 1, 1999, was between Optum, a division of UHS, and United on behalf of health plans that were owned and/or managed by

United. Services provided under the agreement included educational information and periodic telephonic pregnancy screening assessments by registered nurses regarding potential risk of obstetrics cases. Fees payable by the Organization, if it chooses these services, were $75.00 for a Medicaid covered person and $60.00 for a non Medicaid covered person. A 5% discount was to be refunded if more than 30,000 cases were serviced and billed for each year the agreement was in effect. The Organization was also obligated to pay for other requested services not described in the agreement provided by Optum at the request of United.

Optum® Services Agreement with Optum, a Division of United HealthCare Services, Inc.

This agreement, effective November 1, 1999, was between Optum, a division of UHS, and UnitedHealthcare, Inc., on behalf of plans that were affiliated with UnitedHealthcare, Inc. UnitedHealthcare, Inc., became the direct parent of the Organization on June 30, 2000, as disclosed in the History section of this report. The agreement superseded and replaced all agreements between Optum and participating plans except for the Optum Health Plan Web Site Letter of Agreement. Agreements superseded and replaced included the Optum Nurseline Services Agreement and the Optum Care24 Services Agreement as previously discussed in this section of the report.

Services provided included:

- Optum Care24 Services to covered persons by telephone via a toll free 24 hours per day, 365 days per year. These services were defined as "Education, information, problem assessment, crisis management and referral for a Covered Person's personal problems relating to issues including, but not limited to, marital/family relations, dependent care and adult care, financial and/or non-employment related legal issues, chemical or alcohol dependency, illnesses, work related problems, general health information, identification of specific health-related concerns, and provision of educational information regarding those concerns." In person sessions were also provided.
- Optum Health and Well Being Information Services which provided a variety of health and well being information searchable by topic, alpha or keyword through an internet web site. A questions and answer service was provided with selected questions being answered daily by professional nurses and counselors. Other services provided included symptoms guide, news summary, live event transcript archive, audio tape library, health and medical terms dictionary, live moderated chat sessions hosting topical experts as "speakers", and unmoderated discussion message boards.
- Optum Nurseline Services provided by professional nurses by telephone 24 hours per day, 365 days per year. These services were defined as general health information, identification of specific health-related concerns and provision of educational information regarding those concerns.

Fees were to be paid by UnitedHealthcare, Inc., and were as follows:

Optum Care24 Services	$0.76 per Covered Person per month
Optum Health and Well Being Information Services	$0.03 per Covered Person per month
Optum Nurseline Services	$0.46 per Covered Person per month

The fees for the Optum Care24 Services and the Optum Health and Well Being Information Services were based on the assumption that there will be a minimum of 6.5 million commercial Covered Persons. UnitedHealthcare, Inc., would make its best effort to limit exceptions to the Covered Persons enrollment in order to meet this assumption. A Covered Person was defined as an enrollee of a participating health plan.

Subordinated Revolving Credit Agreement with United HealthCare Corporation

The Organization entered into an agreement with United effective December 1, 1999, under which the United agreed to lend and re-lend amounts to the Organization for up to $6,000,000. Repayments were subordinate to claims of non-affiliated creditors and loans from non-affiliate lenders of the Organization. Interest would be payable at the one month London InterBank Offered Rate (LIBOR) in effect on the last business day of the calendar month prior to the calendar month for which interest was being calculated plus fifty basis points. The agreement was to be effective through December 31, 2002, and was automatically renewable for additional one year terms unless either party gives written notice within 60 days.

MANAGEMENT

The following directors were elected by the shareholders of the Organization and were serving as of December 31, 1999:

Name	Principal Business Affiliation
Robert G. Adams	President and Chief Executive Officer United HealthCare of Utah
Douglas J. Hasbrouck, M.D.	Medical Director United HealthCare of Utah
Victor E. Turvey	Vice President United HealthCare of Utah

The following officers were elected by the directors and serving as of December 31, 1999:

Position	Name
President and Chief Executive Officer	Robert G. Adams
Treasurer	Allan J. Weiss
Secretary	Brian K. Beutner
Vice President and Medical Director	Douglas J. Hasbrouck, MD
Vice President	Victor E. Turvey
Vice President and Assistant Treasurer	William A. Munsell
Vice President	Diane L. Flottemesh
Assistant Secretary	David J. Lubben

The July 13, 1998, meeting of the board of directors witnessed the acceptance of resignations from three executive officers, the president and chief executive officer, the executive vice president and a vice president and assistant treasurer. The president also resigned as a director. The board elected a new director, to also serve as president, chief executive officer and chairman of the board, and a new vice president and assistant treasurer.

No committees of the board of directors were designated or functioned during the examination period.

CONFLICT OF INTEREST

The Organization had an established procedure for disclosure of any material conflict of interest known by the officers or members of the board of directors. Annual written declarations were required from officers and members of the board of directors.

CORPORATE RECORDS

The Articles of Incorporation and the By-Laws were reviewed. No amendments or changes were noted throughout the examination period.

Minutes for the meetings of shareholders and board of directors were reviewed. No meetings of either body were held during 1997. The board resumed regular meetings commencing July 13, 1998. This was considered to be in non-compliance with both the Articles of Incorporation and the Bylaws. The thirteenth article of the Articles of Incorporation provided for annual elections of directors by the shareholders, and Article II, section 2.01, and Article III, section 3.03, of the bylaws also provided for annual meetings of the shareholders. Article IV, section 4.02 of the bylaws provided for the annual election of officers by the board as well.

Approval of investment activity for the period of examination was sporadic through July 27, 1998. The board accepted investment reports of acquisition and dispositions on December 20, 1996, for the entire period of January 1, 1994, through November 30, 1996, and then, on August 10, 1998, approved a report of investment transactions for the period of December 31, 1996, through March 31, 1998, spanning the year 1997 in which no meetings were held. Refer to the subsection of this report entitled Status of Prior Examination Findings for further details. Quarterly reviews and approvals of investment activity occurred through the remainder of the examination period commencing with the July 27, 1998, board meeting.

INTERNAL SECURITY

The Organization had fidelity insurance coverage, as a subsidiary of United, in effect for a limit of up to $5,000,000 with $250,000 deductible. They were also provided coverage for both professional liability and directors and officers liability with a coverage limit of $10,000,000 per occurrence for each coverage.

UHS provided internal audit services as provided under an affiliate management agreement, which was discussed in more detail under the Management Agreement with United HealthCare Services, Inc., subsection of this report. The Organization had annual statutory audits performed by its audit firm for each

year covering the examination period, although no external audits were required under the Utah Insurance Code.

TERRITORY AND PLAN OF OPERATION

The Organization had a Certificate of Authority authorizing it to operate as a health maintenance organization in the State of Utah. It had contracts with approximately 2,319 independent physicians and other health care providers, using a network model, to deliver health care services to its members in Box Elder, Davis, Weber, Salt Lake, Carbon, Morgan, Juab, Utah, Summitt, Emery, Wasatch, Uintah, Duchesne, Tooele, Cache, and Washington Counties.

New and renewal business was solicited by in-house agents and outside independent agents.

The Organization targeted groups having one hundred or more employees, however, it would accept groups with as few as five. It did not accept individual members except as conversions from group contracts.

Enrollment as of December 31, 1999, was comprised of the following:

Classification	Member Enrollees
Group:	
Commercial	141,773
Medicaid	27,452
Individual	296
Total	169,521

The Organization had no local advertising policy or budget.

PROVIDER CONTRACTS

The Organization furnished the provider contracts used by them for review. Those reviewed included the Hospital Participation Agreement, the Physician Participation Agreement and the Medical Group Participation Agreement. No discrepancies were noted.

The Organization contracted with approximately 3,000 independent physicians and other health care providers to deliver health care services to its members. The following were the mechanisms for payment specified in the related contracts:

Type of Provider	Method of Payment
Physician	Fee-For-Service, Capitation
Hospital - Inpatient	Per Stay, Per Diem, Case Rate, Percent of Charge
Hospital - Outpatient	Per Visit, Percent of Charge
Hospital - Pharmaceutical	If not included in inpatient or outpatient rate, then Average Wholesale Price +/- a percentage
Mental Health and Chemical Dependency Services	Capitation
Other	Per Diem, Per Hour, Per Visit, Flat Rate or Percent of Charge

RATES

Considerations in the Organization's development of its rates included benefit design, case characteristics and the health status of groups seeking coverage. Rates for small groups were filed with the Utah Insurance Department on a file and use basis. Large groups of 50 plus employees were rated on past claims information, when available, and were quoted on either a "composite" basis of single/family, single/two party and family, or on a single, employee plus child(ren).

REINSURANCE

The Organization had obtained reinsurance coverage through an agreement with United HealthCare Insurance Company, then know as United Health and Life Insurance Company, effective January 1, 1998, until terminated. Coverage under this agreement was for eligible inpatient services with a deductible of $150,000 per member per contract year. Reinsurance payable was 80% of the loss in excess of the deductible per contract year for these services. The maximum payable was $1,000,000 for each member for the life of the agreement. Premiums per member per month were $1.30 as of December 31, 1999, but were subsequently reduced to $1.26 as of January 1, 2000.

The Organization had entered a reinsurance agreement with Transamerica Occidental Life Insurance Company with a coverage period of July 1, 1999, through June 30, 2000. The agreement covered members and services under a Medicaid contract between the Organization and the Utah Department of Health. Retention amounts per covered person per period of reinsurance was $40,000 for all approved transplants except kidney, liver and cornea transplants, and $50,000 for all other services and kidney, liver and cornea transplants. Reinsurance payable in excess of these retention limits was 80% for services provided by participating, nonparticipating and referral providers, except the percentage was 85% for nonparticipating or referral physician services. The maximum reinsurance payable per covered person per period of reinsurance (coverage period) was $950,000. The premium rate was $6.60 per member per month.

RISK SHARING AGREEMENTS WITH GOVERNMENT ENTITIES

The Organization was a party to an agreement with the Utah Department of Health where it was required to provide medically necessary services to Medicaid eligible enrollees. The agreement was effective for the period of July 1, 1999, through June 30, 2004. It had provisions for the above described reinsurance agreement with Transamerica Occidental Life Insurance Company, and also included a risk sharing provision under which the Utah Department of Health would reimburse United HealthCare of Utah for claim costs in excess of premiums paid and other payments including reinsurance received and third party payments.

The Organization was party to another agreement with the Utah Department of Health which provided a managed care program for Utah's Title XXI population; a Children's Health Insurance Program known as CHIP. The agreement included stop-loss provisions under which the Utah Department of Health was to bear 80% of inpatient and outpatient claims paid in excess of $40,000 per date

of service for a CHIP enrollee per contract year. The agreement also provided for reimbursements from the Utah Department of Health in the event claim expenditures exceed 94% of the premiums paid plus other contract payments (which included stop loss payments.)

GRIEVANCE PROCEDURES

The Organization had written complaint/grievance procedures in place. These procedures were reviewed and no discrepancies were noted. All grievances received by the Organization were to be routed to the appealer screener who would log them into the tracking system and acknowledge receipt of the grievance within five days. Complaints filed with the Utah Insurance Department were also logged by the appealer screener. All grievances which were not resolved at this level were to be brought to the appeal committee. This committee could utilize any relevant sources of information necessary to make a decision.

A second level review involving clinical issues included at least one practitioner in the same or similar specialty that manages that medical condition. Members were to be informed of their right to file an appeal with the Department of Insurance, if they were not satisfied with the Organization's decision.

The Organization also had an external review, "Physician Care Review Program" in Massachusetts where complaints may be sent for review.

The grievance procedures that existed in the Organization's HMO Certificate of Coverage was reviewed. The procedures did contain the member's right to take the grievance to the Office of the Commissioner of Insurance, if they did not agree with the decision of the appeals process.

The Organization generally handled complaints according to their guidelines and in compliance with Utah statutes and regulations. No pattern of specific type of complaints was found.

Complaint File Review

Twelve hundred seventy six grievances were received by the Company for the period 1998 through 1999, including 56 (eight justified) complaints filed with the Utah Insurance Department. A random sample of 48 grievance files were requested for review, including 24 of those filed with the Utah Insurance Department and 24 direct complaints. The results of this review follows:

- One complaint was denied as not being treated by a participating provider. However, the lab work was sent to the non-contracted provider by a contracted provider. This was not in compliance with Utah Administrative Code (UAC) Rule R590-76-7(E).
- Five Department of Insurance complaints were not responded to within the statutory guidelines (15 days) as required by UAC Rule R590-192(7)(9).
- Written Organization procedures required resolution of the complaint within thirty days of receipt of the complaint. Three of the complaints reviewed were not resolved within the required thirty day period.

ACCOUNTING PROCEDURES

Accounting functions necessary for the Organization's operation were performed by the parent or affiliate companies under service agreements as disclosed in the section of this report entitled Transactions with Affiliates. Most premium, claim and receivable processing was done through data processing equipment and software in affiliate facilities in Duluth, Minnesota, while accounts payable were processed mainly in Minnetonka, Minnesota. The general ledger and accounting functions were done on an accrual basis in Edina, Minnesota. Affiliates maintained registers, subledgers and financial detail records for premiums, claims and receivables, which were posted to the general ledger on a periodic basis. Examination fieldwork was primarily conducted from the offices of the Organization's parent in Edina, Minnesota, since this was the location of the accounting function.

Lengthy examination delays and problems were encountered when samples were taken from detail premium receivable, claims and unearned premium listings, and difficulties were encountered locating and supporting determinate data in these samples, including tracing premiums and claims to group and member source documents, invoices, disbursement records and receipt records. Problems were also encountered while the Organization was responding to a request for all affiliate and reinsurance agreements, as referred to in the Affiliate Transactions and Reinsurance sections of this report, where several requests and discoveries were made in an effort to obtain a current complete set of affiliate agreements.

Existing securities custodial agreements were not in compliance with Rule R590-178, as discussed in detail under the Notes to Financial Statements section of this report. The Organization's attempts to correct the agreements were lengthy and extensive involving repeated reviews of various agreements by the examiner at their request. Over six months elapsed before the Organization had all custodial securities in the custody of custodians with appropriate custodial agreements.

Affiliates provided the internal audit function, and an affiliate external audit firm provided annual statutory audits, as discussed in the Internal Security section of this report, and performed a SAS 70 review of the affiliate claims systems under which the majority of the Organization's claims were processed. An information systems disaster recovery plan was in place for the affiliate systems.

SCOPE OF EXAMINATION

The Organization was last examined as of December 31, 1995, by a representative of the Utah Insurance Department. The current examination covered the intervening period from January 1, 1996, through December 31, 1999, and included any material transactions and/or events occurring subsequent to December 31, 1999, which were noted during the course of the examination. The Organization was not licensed, nor were any direct premiums reported, in any state other than the State of Utah.

The examination included a review and analysis of the Organization's operations and the manner in which its business was conducted during the examination period, and a determination of its financial status as of December

31, 1999. All phases of the examination were conducted to determine compliance with generally accepted regulatory accounting standards and conformity with the insurance laws of the State of Utah and insurance rules promulgated by the Utah Insurance Department. Reliance was placed on certain workpapers and reports obtained from the audit firm retained by the Organization concerning receivables from reinsurers.

Status of Prior Examination Findings

Items of significance commented on in the prior examination report and their current status are summarized below:

1. "The Organization was in violation of Section 31A-25-201(1) by providing administrative services for indemnity policies without a third party administrators license."

   This comment was based on an affiliate agreement with United Health and Life Insurance Company, which remains active and unchanged, and under which the Organization continues to receive revenues. The agreement clearly listed administrative duties which the Organization must perform as requested for indemnity policies and out-of-area policies. The Organization indicated, in follow up correspondence, that all administrative services for indemnity policies were transferred and performed by UHS.

2. "The Organization's Amended and Restated Bylaws directed there shall be no less than three members on the board of directors. On the examination date, there were only two members on the board of directors."

   The resignation of two directors was accepted, and two directors were elected by written action of the board of directors as of November 12, 1996, in response to the comment in the examination report. Three directors were elected to the board of directors in the December 20, 1996, stockholders meeting. There were no subsequent meetings of stockholders until December 1, 1998, and these directors were listed as directors in the December 31, 1997, annual statement and remained in office until the July 31, 1998, board of directors meeting. This was in non compliance with the Articles of Incorporation, Article 13, which specifies that the directors shall be elected annually by the shareholders. This problem was referred to under the section of the report entitled Corporate Records.

3. "The Board of Directors did not formally review and ratify investment transactions for the years ending December 31, 1994, and December 31, 1995. This is a continuing exception from the prior examination."

   All subsequent investment transactions were found to have been reviewed and approved by the board of directors except for the month of December, 1996. However, no reviews or approvals were made by the board of directors from December 20, 1996, through July 27, 1998, over the period which there were no meetings. The board subsequently approved all transactions during the period except for the aforesaid month of December. All investment transactions were reviewed and

approved by the board of directors on a quarterly basis subsequent to the July 13, 1998, meeting.

4. "The Bylaws required the Board of Directors to review and approve signatories to the checking accounts "from time to time". Only in February, 1994, did the Board review and approve specific signatories to the checking accounts. (This is a continuing exception from the prior examination.)"

   Follow-up correspondence from the Organization stated that account signatories would be reviewed and ratified in all future board of director meetings. Signatories were reviewed and authorized only once during the examination period, in the December 20, 1996, meeting of the board of directors.

5. "A vice-president was authorized by the chief executive officer to sign checks and conduct business with a bank for a seventeen day period. The minutes of the board meetings did not indicate the board authorized or approved the vice-president as a check signer."

   The Organization agreed with the findings in follow-up correspondence and indicated that appropriate authorization and approvals from the board would be obtained in the future. Subsequently, on December 20, 1996, the board adopted a "generic" resolution authorizing "Any person or persons designated in a written certificate signed by the Chief Executive Officer and the Secretary or the Assistant Secretary of the Corporation (and such officers of this Corporation may appoint themselves as the persons authorized to sign)" as check signers. However, this does not comply with Article V, Section 5.02, of the bylaws either which stipulates that "All checks, drafts or other orders for payment of money, notes or other evidence of indebtedness, issued in the name of or payable to the Corporation, shall be signed or endorsed by such person or persons and in such manner as, from time to time, shall be determined by resolution of the Board."

6. "The Organization did not observe conventional regulatory accounting standards relating to the recognition of premiums receivable over ninety (90) days past due."

   The Organization responded in follow-up correspondence that an allowance for uncollected accounts was maintained on the balance sheet of United HealthCare of Utah and requested that the balance in that account be netted against balances over ninety days past due for purposes of inclusion as an admitted asset. The Organization still followed the same practice as of the date of examination.

7. "Invested assets of the Organization were maintained through a bank in non compliance with UCA Section 31A-4-108. (This is a continuing exception from the prior examination.)"

   The Organization subsequently transferred the investment to an approved custodian account. However, it was revealed that all invested assets, as of December 31, 1999, were found to be kept under custodial agreements which were also in non compliance UCA Section 31A-4-108

due to the adoption of UAC Rule R590-178 in 1996.

8. "The Organization's encounters with non contracted providers was greater than 10% of total encounters."

   The Organization's response in follow-up correspondence was to continue to pursue contracts with all providers who provide covered benefits to members. The problem had been rectified by the end of this examination period.

FINANCIAL STATEMENTS

The statements listed below are presented immediately following in this report.

Balance Sheet, December 31, 1999

Statement of Revenue and Expenses, Year Ending December 31, 1999

Statement of Changes in Net Worth, 1995 Through 1999

The notes to the financial statements are an integral part of the financial statements.

United HealthCare of Utah
Balance Sheet
December 31, 1999

Assets

		Notes
Cash and Short-term Investments	$ 5,471,328	(1)
Premiums Receivable	3,829,501	
Investment Income Receivables	439,888	
Health Care Receivables	5,088,137	(2)
Reinsurance Recoverable on Paid Losses	0	(3)
Bonds	30,611,787	(4)
TOTAL ASSETS	$45,440,641	

Liabilities and Net Worth

Accounts Payable	173,346	(5)
Claims Payable	27,965,090	(6)
Unearned Premiums	638,627	
Amounts Due to Affiliates	4,356,439	(7)
Aggregate Write-ins for Current Liabilities:		
Claims Processing Expenses	1,280,002	(8)
Broker Commissions	1,141,046	
Current Income Taxes Payable	813,869	
Other Payables	158,226	
TOTAL LIABILITIES	36,526,645	
Common Stock	118,950	
Paid in Surplus	9,148,590	
Retained Earnings/Fund Balance	-353,544	(9)
TOTAL NET WORTH	8,913,996	
TOTAL LIABILITIES AND NET WORTH	$45,440,641	

Statutory Surplus Allocation:

Minimum Capital	$ 100,000
Compulsory Surplus	5,144,800
Surplus	3,669,196
Total Net Worth	$8,913,996

United HealthCare of Utah
Statement of Revenue and Expenses
Year Ending December 31, 1999

Revenues

Premiums	$223,571,767
Net Investment Income	1,821,327
Miscellaneous Revenues	105,270
TOTAL REVENUES	225,498,364

Expenses

Physician Services	65,541,071
Other Professional Services	206,026
Inpatient	50,092,965
Aggregate Write-ins for Other Medical and Hospital Expenses:	
Pharmacy Net	23,018,506
Mental Health Capitation	7,597,581
Outpatient	45,228,986
Other Capitation and Medical Expenses	1,500,467
Subtotal	193,185,602
LESS:	
Net Reinsurance Recoveries Incurred	4,245,080
COB and Subrogation	-77,988
Subtotal	4,167,092
Total Medical and Hospital	189,018,510
Administrative Expenses	39,517,467
TOTAL EXPENSES	228,535,977
INCOME OR LOSS (-)	-3,037,613
Provision for Federal Income Taxes	-1,287,000
NET INCOME OR LOSS	$ -1,750,613

United HealthCare of Utah
Statement of Changes in Net Worth
1995 Through 1999

	1995	1996	1997	1998	1999
Net Worth, Beginning of Year	$ 6,212,168	$ 6,690,992	$ 4,758,905	$ 6,428,934	$ 6,851,568
Increase in Contributed Capital			2,500,000		4,000,000
Net Income or Loss	62,988	-1,475,587	-1,037,720	-305,103	-1,750,613
Decrease or Increase in Non-Admitted Assets	415,836	-456,500	207,749	727,737	-186,959
Net Worth, End of Year	$ 6,690,992	$ 4,758,905	$ 6,428,934	$ 6,851,568	$ 8,913,996

NOTES TO FINANCIAL STATEMENTS

(1) Cash and Short-term Investments **$5,471,328**

The majority of the Organization's cash equivalents and short term investments, $9,253,008, were maintained under a custodial agreement which was deemed not to be in compliance with the Utah Administrative Code (UAC) Rule R590-178. The Organization subsequently supplied an executed amendment to the agreement, approved by the board of directors, which was in compliance with the Rule. These assets were allowed for the purposes of the report.

(2) Health Care Receivables **$5,088,137**

The receivable was increased by $2,164,892 due to the reclassification of amounts reflected under reinsurance recoverable on paid losses, page 2, line 6, of the December 31, 1999, annual statement. Refer to that item under Notes to Financial Statements for further details.

(3) Reinsurance Recoverable on Paid Losses **$0**

The Organization wrote off $674,808 from this asset in July of 2000. These amounts were due from its affiliate, United HealthCare Insurance Company. It was determined that $593,670 of this amount was for receivables outstanding as of December 31, 1999, and the asset was reduced by this amount for the purposes of this report. Net worth was also reduced by an equivalent amount.

The remaining balance of $2,164,892 was reclassified to health care receivables which was considered a more appropriate classification considering allowable assets as defined under UAC Rule R590-76.

(4) Bonds **$30,611,787**

All of the Organization's long term bonds, $30,611,787, were maintained under two custodial agreements which were deemed not to be in compliance with the UAC Rule R590-178. One agreement was subsequently amended, approved by the board of directors and executed, and was in compliance with the Rule. An agreement with a new bank was subsequently approved by the board of directors and executed which did comply with the Rule. All remaining custodial securities were subsequently transferred to the new custodian. These assets were therefore considered allowable for the purpose of this report.

(5) Accounts Payable **$173,346**

Errors were made in accrual and payment entries to the general ledger. These errors involved the accrual of amounts due and advances receivable from providers and the subsequent payment or receipt. One error originated in December of 1998 and the other in January of 1999. Correcting entries were made in March and June of 2000. The result was an understatement of the accounts payable item and an overstatement of the amounts due to affiliates item of $352,125.

(6) Claims Payable **$27,965,090**

Redundancies were revealed in the full year development of the December 31, 1999, liability which consisted of $57,386 for IBNR reserve, $1,462,303 for the IBNR margin reserve and $205,465 for the extended benefits reserve. The liability was reduced and net worth was increased appropriately.

No liability was established for the payment of settlement and benefits expenses on claims payable or unreported claims, as required by UAC Rule R590-16-12(C)(2). Using an industrial percentage of 5% for IBNR, and 2 ½% for claims payable, it was estimated that this liability would have been $1,280,002. A claims processing expenses account was created for this amount under aggregate write-ins for current liabilities. Net worth was also decreased by this amount for the purposes of this report.

(7) Amounts Due to Affiliates **$4,356,439**

This liability was reduced by $352,125 for errors discussed under the Accounts Payable subsection of this report.

(8) Claims Processing Expenses **$1,280,002**

This liability was increased by $1,280,002 as discussed under the Claims Payable subsection of this report.

(9) Net Worth **$8,913,996**

Adjustments to balance sheet items, as reflected below, resulted in a decrease in net worth of $148,518.

Account	Organization	Examination	Change in Net Worth
Health Care Receivables	$ 2,923,245	$ 5,088,137	$2,164,892
Reinsurance Recoverable on Paid Losses	2,758,562	0	-2,758,562
Accounts Payable	-178,779	173,346	-352,125
Claims Payable	29,690,244	27,965,090	1,725,154
Amounts Due to Affiliates	4,708,564	4,356,439	352,125
Claims Processing Expenses	0	1,280,002	-1,280,002
Total Change			-148,518
Net Worth Reported			9,062,514
Net Worth per Examination			$8,913,996

SUMMARY

1. The board of directors accepted the resignation of three executive officers in the July 13, 1999, meeting. **(MANAGEMENT)**
2. No meetings of the shareholders or board of directors were held during all of 1997 and up to July 13, 1998. This was in non compliance with portions of both the Articles of Incorporation and the Bylaws. Regular periodic meetings were held subsequently. **(CORPORATE RECORDS)**
3. The review of complaint files revealed the following problems and exceptions. **(Complaint File Review)**:
    - Denial of a claim for a non-contracted provider which was referred to by a contracted provider, in non compliance with UAC Rule R590-76-7(E).

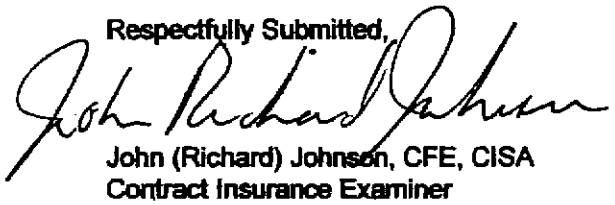
- Department of Insurance complaints were not responded to within the statutory guidelines of 15 days as required by UAC Rule R590-192(7)(9).
- Complaints were not resolved within a thirty day period in accordance with written Organization procedures.

4. The Organization had difficulty locating and supporting determinate data such as member source documents, invoices, disbursement records and receipt records requested during substantive testing of premium and claim balance sheet items. They also had difficulty locating and providing copies of all of their affiliate and reinsurance agreements. **(ACCOUNTING PROCEDURES)**
5. The Organization was cited for non compliance with UCA Section 31A-25-201(1) for providing administrative services for indemnity policies without a third party license in the prior examination report. This was based on an administrative agreement which was still in effect and required the same services by the Organization. **(Status of Prior Examination Findings)**
6. No periodic reviews and approval of investment transactions were made by the board of directors for the period of December 20, 1996, through July 27, 1998. This was an exception from the prior examination, and the examination prior to that. **(Status of Prior Examination Findings)**
7. The bylaws required the board of directors to review and approve signatories to the checking accounts "from time to time". Only in December of 1996 did the board review and approve specific signatories to the checking accounts. This was an exception from the prior examination, and the examination prior to that. **(Status of Prior Examination Findings)**
8. The board adopted a "generic" resolution authorizing certain executive officers to certify any person or persons as designated check signers. This did not comply with Article V, Section 5.02, of the bylaws. **(Status of Prior Examination Findings)**
9. The majority of the Organization's invested assets were held under custodial agreements which were not in compliance with UAC Rule R590-178. This was an exception from the prior examination, and the examination prior to that. **(NOTES TO FINANCIAL STATEMENTS #1 and #4, and Status of Prior Examination Findings)**

CONCLUSION

The assistance and cooperation extended during the course of the examination by officers, employees and representatives of the Organization was appreciated.

Respectfully Submitted,



John (Richard) Johnson, CFE, CISA
Contract Insurance Examiner
Representing the Utah Insurance Department